



## Financial Policy

Thank you for choosing us as your primary care providers. We are committed to providing you with quality and affordable health care. In order to reduce misunderstandings, we have adopted the following Financial Policy. We require that you read it carefully, initial each numbered section in the space provided, and sign at the bottom prior to the start of any treatment.

**1. Insurance:** If you are not insured by a plan we do business with, payment in full is expected at each visit. If we accept your insurance but you don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. It is your responsibility to know your insurance benefits including deductibles, copayments as well as contracted lab, radiology and hospital facilities. Please contact your insurance company with any questions you may have regarding your coverage. It is your responsibility to notify our office of any change in your insurance coverage. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

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**2. Co-Payments, Deductibles & Co-Insurance:** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments can be considered fraud. Patients with deductibles are required to pay 50% of the amount due at the time of service. For those with co-insurance 5% of the amount due will be collected at the time of service.

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**3. Non-Covered Services:** All health plans are not the same, and they do not always cover the same services. Please be aware that some of the services you receive may be determined to be "not covered" by your health plan. You must pay for these services in full.

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**4. Proof of Insurance:** We will bill your insurance on the information you provide us at the time of service. This requires us to copy your current insurance card. We will also require you to confirm your registration information. Your failure to provide us with the correct information could result in the denial of your claim. If this occurs, you assume responsibility for the entire amount of the claim.

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**5. Claims Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. **If your insurance company does not pay your claim within 60 days, the balance will automatically be billed to you.**

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***CONTINUED ON OTHER SIDE***

**6. Billing Statements & Statement Fees:** Patient's balance statements are sent out on a monthly basis. The first statement is provided at no charge. Each subsequent statement for the same unpaid claim will be subject to a \$5 Statement / late fee.

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**7. Non-Payment:** If your account is over 90 days past due and there has been no communication with our billing department, you and your immediate family members could be discharged from our practice. In addition, your account could be sent to collections.

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**8. No Show / Late Cancellation Fees:** We charge \$25 for missed appointments and for appointments not cancelled with at least 24 hours notice. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment.

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**9. Minors:** A parent/legal guardian must accompany a minor patient on his first visit to our office so we can obtain a signature to treat the minor patient. A minor may be treated on subsequent visits without a parent/guardian if we have a written permission. The adult accompanying the minor patient is responsible for the payment of the rendered service at the time of service.

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**Miscellaneous Charges:**

FMLA	\$30
Disability Forms	\$30-100
Misc. Forms	\$15-100
Insurance Forms	\$50-100
Patient Records	\$35
<i>(Personal Copy)</i>	

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. A copy will be available upon request.

**I have read and understand this payment policy:**

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**Signature of patient or responsible party**

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**Date**